Midwife, Ms A

A Report by the

Health and Disability Commissioner

(Case 14HDC01440)

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Executive summary

1. In 2014, Mrs D (aged 32 years at the time of events) was pregnant with her first child. She engaged a community-based midwife, Ms A, as her lead maternity carer.[1] At the first midwifery appointment standard antenatal information was provided, including plotting a growth chart; safe eating; diet and routine well-being testing.

2. Regular midwifery appointments and scheduled ultrasound scans took place. The scan at 21 weeks' gestation (23 Month4[2]) revealed a low-lying placenta, and the radiologist advised that a further scan should take place at 32 weeks' gestation (8 Month7). Ms A discussed the low-lying placenta with Mrs D at an appointment on 2 Month6.

3. The next appointment took place on 8 Month7 at 32+5 weeks' gestation. At that appointment, Ms A recorded in the clinical notes the "need to follow-up" the 32-week scan. Ms A told HDC that Mrs D told her that she had had the scan done and it was "all normal". Ms A did not follow up on the 32-week scan, which had not taken place.

4. Further midwifery appointments took place on 25 Month7, 8 Month8 and 16 Month8, and normal antenatal clinical assessments were recorded.

5. On 22 Month8 Mrs D's husband, Mr D, telephoned Ms A at 4.22am and again at 7.30am and advised her that Mrs D had unbearable lower abdominal pain. Ms A suggested comfort measures to Mrs D over the telephone, advised that labour appeared to be starting and what to expect, and said she would visit later in the day.

6. Mr D telephoned Ms A at 3.30pm and requested an urgent home visit. Ms A arrived between 4.30pm and 4.45pm. Mrs D told HDC that she was in constant pain. She consented to Ms A performing some assessment by touching her stomach, but then withdrew her consent for further examination. Ms A recorded in the clinical notes that Mrs D was not in established labour, and advised Mr D to contact her if contractions became closer together and stronger.

7. Mr D telephoned Ms A at 9.37pm and said that Mrs D was experiencing stronger labour pain. Ms A listened to Mrs D over the telephone, suggested further comfort measures, and advised that it was not yet time to go to hospital. At 11.34pm Mr D told Ms A that Mrs D was experiencing more frequent pain and that they were going to the hospital. Mrs D arrived at the public hospital at 12.22am on 23 Month8. She was met there by Ms A, who assessed Mrs D and could not find a fetal heartbeat.

8. At 12.44am Mrs D delivered a stillborn baby girl. The cause of death was moderately severe chorioamnionitis[3] with chronic vessel vasculitis and associated thrombosis.

[1] The LMC is responsible for organising a woman's maternity care and developing the care and birth plans.

[2] Relevant months are referred to as Months 1-8 to protect privacy.

[3] Inflammation of fetal membranes owing to bacterial infection.

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Findings

9. Ms A failed to provide services to Mrs D with reasonable care and skill by failing to follow up the advice from the radiologist and ascertain whether a 32-week ultrasound scan had been performed. Additionally, Ms A failed to arrange a full assessment of Mrs D, either in her home or at hospital, at 9.37pm on 22 Month8. For these reasons, Ms A breached Right 4(1)[4] of the Code.

10. At the home visit at 4.30pm on 22 Month8, when Ms A interpreted Mrs D's comments and actions as declining further assessment, Ms A did not explain the reasons for performing a further examination, what the examination would involve, and the consequences of not doing an examination. This was information that a reasonable consumer in Mrs D's circumstances required before making the choice to refuse consent. Accordingly, Ms A also breached Right 6(2)[5] of the Code.

11. By failing to document significant events, discussions and decisions, Ms A did not meet professional standards and, accordingly, she breached Right 4(2)[6] of the Code.

Complaint and investigation

12. The Commissioner received a complaint from Mrs D about the services provided to her by midwife Ms A. The following issue was identified for investigation:

    The appropriateness of the care provided to Mrs D by Ms A.

13. An investigation was commenced on 3 August 2015.

14. The parties directly involved in the investigation were:

Ms A	Provider/community-based midwife
Mrs D	Consumer/complainant
Mr D	Consumer's husband
District Health Board	Provider

Also mentioned in this report:

Dr B	Paediatric registrar
Ms C	Support group

15. Information was received from the above parties and the Midwifery Council of NZ.

16. Independent expert advice was obtained from midwife Kerry Adams (**Appendix A**).

[4] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[5] Right 6(2) states: "Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."
[6] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Information gathered during investigation

Background

17. In 2014, Mrs D (aged 32 years at the time of these events) was pregnant with her first child. She engaged a self-employed community-based midwife, Ms A,[7] as her lead maternity carer (LMC).[8]

18. On 14 Month1, at 7+5 weeks' gestation, Mrs D had her first antenatal appointment at her home. During the appointment a detailed discussion took place, and standard information was provided including plotting a growth chart; safe eating; diet; and routine well-being testing during pregnancy. Mrs D's blood pressure was taken and her current gestation was calculated. An LMC Services Maternity Booklet was provided along with Ministry of Health registration and hospital booking forms. The front page of the Maternity Booklet included the contact details of a backup LMC.

Ultrasound scans

19. Four ultrasound scans took place — at 7 weeks, 12 weeks, 21 weeks and 24 weeks. Mrs D said that, each time, the process was that she called the ultrasound clinic herself and arranged an appointment with the radiologist. A report would be sent to Ms A, who discussed the findings with Mrs D. The radiologist's report dated 23 Month4 (at 21 weeks) stated that the placenta was low lying and directed that a further scan should take place at 32 weeks (on 8 Month7) to review the placental position. The radiologist's report dated 9 Month5 (at 24 weeks) again noted the need to "reassess the placenta" at 32 weeks.

Assessments

20. A further eight midwife appointments took place from 31 Month2 to 25 Month7.

21. Ms A told HDC that the care/birth plan discussion continued at the midwifery appointment on 4 Month5. She told HDC that on 2 Month6 she "discussed the scan report with [Mrs D] at which time she was fully informed about the low-lying placenta". On 25 Month6 routine antenatal assessments were carried out and there was a further discussion about the care and birth plan.

22. The next appointment on 8 Month7 at 32+5weeks' gestation took one hour. Ms A recorded in the clinical notes for that day: "[N]eed to follow-up at [the ultrasound clinic]." She told HDC that there was a discussion at that appointment around the need to do a follow-up scan, "but [Mrs D] said she had done the scan and it was all normal".

23. Mrs D told HDC that after 32 weeks' gestation, Ms A said: "No, [the baby is] fine, you don't need the [fifth] scan." Mrs D told HDC that she "didn't know [she] needed to go" for another scan.

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[7] Ms A has been a registered midwife for many years, and has worked as a self-employed community-based midwife since 2010.

[8] The LMC is responsible for organising a woman's maternity care and developing the care and birth plans.

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24. Ms A told HDC:

> "If I had used the words 'baby is fine', it would only have been in the context of the reassuring assessments as indicated by a normal range of growth plotted on the customised growth chart and a normal foetal heart rate, as auscultated. …
>
> Had I indeed provided the advice ['you don't need the fifth scan'] there would have been no reason for me to discuss the scan again at 32 weeks on 8 [Month7] when I wrote in the note 'need to follow-up at the [ultrasound clinic]."

25. Ms A said that she forgot to follow up whether Mrs D had in fact had the 32-week scan performed, and did not contact the ultrasound clinic to obtain the scan report.

26. Mrs D had three further appointments with Ms A on 25 Month7, 8 Month8 and 16 Month8, and normal antenatal clinical assessments were recorded.

Events of 22 Month8

27. By 22 Month8 Mrs D was 39 weeks pregnant. Ms A told HDC that, at 4.22am, Mr D (Mrs D's husband) called her and reported that there was a "white discharge when [Mrs D] got up to the toilet". Ms A told HDC that Mr D said Mrs D said that there were "no labour pains and the baby was moving". Ms A said that she established with Mr D that the discharge appeared to be normal vaginal discharge, and did not speak directly to Mrs D.

28. Ms A said that at 7.30am Mr D called her again and reported that Mrs D had a "watery and white" discharge and "lower abdomen pain in the pubic area", and "she could not bear it". Ms A talked to Mrs D, who told her that she had "unbearable period pains". Ms A told HDC that Mrs D said that these pains were short in duration and occurring approximately every 10 minutes. Ms A said she advised that labour appeared to be starting and suggested comfort measures over the telephone and advised what to expect when labour became stronger. Ms A said she told Mrs D that she would visit later in the day, but did not give an indication of when she would arrive.

Home visit

29. At 3.30pm Mr D called Ms A requesting an urgent home visit. Ms A told HDC that she arrived between 4.30pm and 4.45pm. Mrs D told HDC that Ms A had been expected at 3pm.[9]

30. Ms A went into Mrs D's bedroom, where she was in bed. Mr D was also present in the bedroom.

Mr and Mrs D's account

31. Mrs D said that Ms A asked her how she was feeling, and Mrs D replied that she was in "quite a lot of pain". Mrs D told HDC that she was in "constant" pain. She told HDC that she said to Ms A once only, "Please don't touch me," and Ms A replied, "I need to touch you." Mrs D said that she agreed and, with consent, Ms A placed one

[9] There is no record of a home visit having been pre-arranged.

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finger on Mrs D's abdomen and said: "[Y]our stomach is not tight enough, you are not in labour." Mrs D said: "[I was in] no condition to move or do something. [Ms A] touched my stomach to check and because of the pain I may have [withdrawn consent] but I am not sure."

32. Mrs D said that Ms A also checked under the bed covers. Mrs D told HDC she was embarrassed about this because "there were lots of fluids and [faeces] in the bed". Mr D told HDC that after Ms A looked under the bed covers, she said to him: "[I]t is not her waters, it is green stuff." Mr D said that he did not know what that meant.

33. Mrs D told HDC that there were no other interactions with Ms A, who left the bedroom after her assessment.

34. Mrs D said that her eyes were "sometimes open, sometimes closed" at that time, and Ms A went into her bedroom only once. Mr D said that Ms A "[w]ent in and out — two minutes, max". Mr D told HDC that Ms A did not carry out any further assessments, and did not ask him whether Mrs D was sleeping.

35. Mr D told HDC that after seeing his wife in the bedroom, Ms A walked straight out of the house to her car. He said that he followed her out and asked her what was happening and that, as Ms A was opening her car door, she said she would let them know the right time for Mrs D to go to hospital.

Ms A's account

36. Ms A told HDC in response to the complaint:

> "When I arrived [at the house] … [Mrs D] was in bed and appeared to be asleep. She did not respond when I called her name and advised that I was there to check her baby and progress. She did not respond to any of my questions. I discussed with [Mr D] that it appeared that [Mrs D] was asleep and did not appear to be in strong labour. [Mrs D] then spoke and said she was not asleep. Her eyes were closed and she was [lying] quietly in the bed. She said she had a pain so I went over and put my hand on her fundus[10] to palpate. She then ordered me not to touch her anymore.
>
> On palpation there was no evident contraction, the pain appeared to be in the lower abdomen, typically cervical cramps; [Mrs D] was not behaving like labour was establishing. I asked to examine her but she said to 'leave me alone'. I asked if I could just look under the covers to check for any discharge. [Mrs D] consented to this action … I observed a clear mucous show. I asked [Mrs D] to at least tell me if the baby was moving, to which she replied affirmatively. Mrs D then continued to close her eyes and lie still and would not respond to me any further when I spoke with her. She did not mention she was in pain, nor did she express any concerns at any time. I went into the living room with [Mr D] to discuss what to do. He said she would not let him touch her either. I confirmed I could not examine her without her permission and had done as much as I could in the

[10] Top of the uterus between the fallopian tubes.

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circumstances. I waited for about 15 minutes in case [Mrs D] changed her mind and agreed to an examination.

…

I said to [Mr D] that women usually go into the hospital when they are in established labour and that [Mrs D] was not asking for that to occur. Before I went out to my car I advised them both to call me if labour became stronger and established or if there were any concerns."

37. However, Ms A also told HDC in response to notification of this investigation:

"I advised [Mrs D] I needed to check her and her baby further to see if they were 'ok'. I called her name a few times when she continued to not respond. I said 'don't you want me to check your baby?' I believe it was made clear to [Mrs D] [that] further assessment was needed to ascertain whether she and baby were ok."

38. Mrs D told HDC that Ms A did not say, "[D]on't you want me to check your baby?" and it was not clear to her (Mrs D) that further assessment of her and her baby was needed. Mrs D said that there was no reference to Ms A checking the baby, and stated that there "wasn't much talk" between them at that time.

39. Ms A told HDC that she has never placed "one finger" on a woman's abdomen to make an assessment: "I always carry out a palpation according to the correct methods. I was able to palpate [Mrs D] briefly before she ordered me not to touch her anymore … I can recall her abdomen was soft — not firm." Ms A said further:

"[Mrs D] did not indicate any embarrassment to me when I asked if I could look under the covers to check for any discharge. [Mrs D] specifically consented to this action. [Mrs D] was lying on her side facing the outside of the bed and looking sideways. I lifted the covers. She was not wearing anything. It is not correct that 'there were lots of fluids and [faeces] in the bed'. I am certain I would have noticed if this was the state of the bed.

I did not tell [Mr D] of the presence of any green discharge. [Mr D's] claim is false. Had I noticed any green discharge I would have taken the appropriate action which was to advise [Mrs D] that the green discharge could indicate the baby was in distress and that we needed to transfer to hospital immediately for further assessment."

40. Ms A told HDC that she was in Mrs D's bedroom for approximately 10–15 minutes and she "remained in the lounge nearby for approximately another 15 minutes and a further 10–15 minutes in the car on the driveway."

41. Ms A's clinical notes state:

"4.45pm. Seen [Mrs D] at home with mucous show at 4.22am. Reports some drips described as watery and white at 7.30am. Some mild contractions 1:10 mins, 30 seconds. At visit not contracting, sleeping in bed — not responding to questions. Touched abdomen. Soft to palpate. Ordered not to touch her. Declined

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examination, would not talk just kept sleeping quietly in bed. Look under cover. Clear mucous seen. Not wearing a pad. Discussed with husband in living area who reports [Mrs D] not letting him touch her either. Impression: not in established labour yet. Left house advising to call if contractions get closer together and stronger — established labour."

Evening telephone calls

42. At 9.37pm Mr D called Ms A again and said that Mrs D was having stronger labour pains. Mr D said that Ms A's advice was that Mrs D should keep breathing, lie down, and try to eat.

43. Ms A said that she listened to Mrs D on the telephone through the pains, which appeared "short and irregular — about 10 and 15 minutes apart". Ms A said that Mrs D said that "[i]t was too sore" and asked about going to hospital, but that she advised Mrs D again about comfort measures and said it was not yet time to go to hospital. Ms A told Mrs D that if she did go, the hospital might send her home again, so it was "generally better to wait until labour was established". Mrs D told HDC that the "plan" was to go to hospital "at the last minute". Ms A said she offered pethidine[11] for the pain, but told Mrs D that pethidine would have to be administered in hospital.

44. In respect of this telephone call, Mr D told HDC:

> "We spoke to [Ms A] … for twenty minutes or so, then she said 'No you can't go to the hospital or they will just send you back home because she is not in labour'. And then she said: 'Can I speak to [Mrs D]' and [Mrs D] was not in the status of speaking to anyone. She was in pain but she still spoke to [Ms A] because, you know, she is the midwife. She was talking to [Mrs D] and then she said 'See you are still not in labour if you are talking to me'."

45. Ms A said that Mrs D's account "would be correct but would not be the sum total of the assessment as to whether [Mrs D] was in labour". Ms A stated:

> "I had a good amount of time to assess [Mrs D] on the telephone and was able to assess from the information she gave me the strength, length and frequency of her pains/contracts. I gave feedback to [Mrs D] accordingly."

46. Mrs D told HDC: "It was our first baby so we didn't go against [Ms A] because we thought she knew what she [was] doing. … We didn't know what to do so we [stuck] to [Ms A's] advice [not to go to hospital until Ms A said so]."

47. At approximately 11.34pm Mr D again called Ms A and said his wife was experiencing more frequent pains. Ms A said she was unable to talk to Mrs D because Mrs D was on the toilet. Ms A told HDC:

> "I then asked if [Mrs D] was on the toilet to pass urine or was [Mrs D] feeling pressure to open her bowels. [Mr D] told me she 'feels pressure and feels like

[11] Pethidine is indicated for the treatment of moderate to severe pain, and is used for women in labour.

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pooing'. I then asked: 'Is she pushing?' and he replied: 'Yes'. I said at that point that [Mrs D] needed to come to hospital."

48. Ms A said she ascertained that Mrs D was "feeling pressure". Ms A stated: "I told [Mr D] that [Mrs D] should come to [the] Hospital. I thought it could be that [Mrs D] had progressed unexpectedly quickly to second stage or the membranes were bulging."

49. In contrast, Mrs D said that when Mr D called Ms A he told Ms A that they were going to hospital. Mrs D said: "We actually had to fight with [Ms A] to go to the hospital."

Rupture of membranes

50. Mrs D told HDC that her waters broke at 4pm (on 22 Month8). Dr B, the on-call paediatric registrar, recorded in the clinical notes after the birth: "Midwife said that earlier in the day mum felt baby move. Waters broke at 7pm. Unclear if meconium present."

51. Ms A stated that she was not told that Mrs D's waters had ruptured at 4pm, and said that Mr D told her that the waters broke in the car on the way to the hospital (at around 11.30pm). Ms A said that she recorded on the Labour & Birth Summary that the membranes ruptured in the 1st Stage "?" and "0730", which indicated her uncertainty about when the membranes had ruptured. She said that she used a question mark because she recalled Mr D saying that the waters broke in the car at approximately 11.30pm, but Dr B had written that the membranes ruptured at 7pm. Ms A said she "assumed [Dr B] had been given further and different information" from what Mr D had told her. Mr D told HDC that he did not say to Ms A that the waters broke in the car, and stated: "Nothing happened in the car."

The public hospital

52. A record in the clinical notes at 11.55pm by nursing staff at the public hospital states: "LMC called to say she is bringing [Mrs D] in as ? labour."

53. At 12.22am on 23 Month8 Mrs D arrived at the delivery unit at the public hospital. Mr D stated: "When we were in the hospital in the labour room [Ms A] was still saying 'No, no, everything is fine, everything is fine'."

54. Mr D said that Ms A checked Mrs D with her hands and used a Doppler[12] but could not find a fetal heartbeat. Ms A then asked Mr D to ring the bell to call for emergency assistance.

55. Ms A said that Mrs D was not showing clinical signs that she was in labour:

> "With her consent I listened to the baby but could not find the fetal heart. … I called the [emergency] bell and advised [Mrs D] that I needed to apply a Foetal

[12] A handheld Sonicaid Doppler device used to listen to the fetal heart.

HDC

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Scalp Clip[13] because I could not hear the baby. I quickly prepared for this and found a peak of the fetal head presenting but no membranes or liquor was seen."

56. Ms A told HDC that the Clinical Charge Midwife and two staff midwives arrived, and they could not find the fetal heartbeat. An obstetrician, the paediatric team, and Dr B then arrived.

57. Ms A said: "We advised [Mrs D] that she needed to get her baby out so we encouraged her to push but the pushing was not very effective and the contractions were not strong."[14]

58. Sadly, Mrs D delivered a stillborn baby girl. The cause of death was established by the histologist as moderately severe chorioamnionitis[15] with chronic vessel vasculitis[16] and associated thrombosis. The baby was recorded as weighing 2375 grams.[17]

Further information — Ms C

59. On 14 April 2015 Mrs D sought assistance from Ms C, from a support group. Ms C was given permission to review Ms A's clinical notes. Ms C made submissions to HDC on behalf of Mrs D, including:

- Ms A failed to exclude late pregnancy praevia[18] by way of an ultrasound scan. If placenta praevia had been diagnosed at a 32-week scan, a transfer to a specialist was required according to the Referral Guidelines.[19] An assessment of fetal well-being could have been made at this time and closer scrutiny arranged if concerns were raised regarding the baby or the placenta;
- Ms A did not respond adequately to Mrs D's concerns on 22 Month8. There is no record of how long Ms A's observations took on the home visit, and there was no attempt to check on the fetal heart rate;
- Ms A has given inconsistent accounts to HDC regarding the home visit — her clinical notes record Mrs D was "sleeping in bed" and "sleeping quietly" yet she also stated that Mrs D ordered Ms A not to touch her and that Mrs D declined an examination;
- It was unclear how Ms A decided that labour had become established 3 hours and 44 minutes prior to the birth — labour and full dilation could have taken place many hours earlier; and
- A quick labour would be unlikely for a person experiencing her first full-term pregnancy.

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[13] A monitor that records the fetal electrocardiogram via a single electrode applied to the fetal scalp (known as a fetal scalp electrode).
[14] On the Labour & Birth Summary 1st Stage record, labour was recorded as having established at 2100 hours.
[15] Inflammation of fetal membranes due to bacterial infection.
[16] Inflammation of the blood vessels.
[17] Average baby weight is 3400 grams (7.5 pounds).
[18] A condition in which the placenta partially or wholly blocks the neck of the uterus, so interfering with normal delivery of a baby.
[19] Ministry of Health.

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Response to provisional opinion

60. Ms A advised that she did not wish to comment on the provisional report.

Relevant professional competencies and standards

61. The New Zealand College of Midwives *Midwives Handbook for Practice* 2008 (as required by the Midwifery Council of New Zealand (MCNZ)) states, relevantly:

> "Competency Two
>
> …
>
> Performance Criteria
>
> The midwife:
>
> …
>
> **2.5** attends, supports and regularly assesses the woman/wahine and her baby/tamaiti and makes appropriate, timely midwifery interventions throughout labour and birth;
>
> …
>
> **2.16** provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided."
>
> "Competency Three
>
> The midwife promotes practices that enhance the health of the woman/wahine and her family/whanau and which encourage their participation in her health care.
>
> Performance criteria
>
> The midwife:
>
> 3.3 promotes self-determination for the woman/wahine and her family/whanau;"
>
> "Competency Four
>
> The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care."

62. The Standards of Midwifery Practice set out in the *Midwives Handbook for Practice* 2008 include, relevantly:

> "**Standard One**: The midwife works in partnership with the woman.
>
> Criteria
>
> The midwife:
>
> - recognises individual and shared responsibilities

- facilitates open interactive communication and negotiates choices and decisions
- is culturally safe
- recognises contribution of both partners

Standard Two: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

Criteria

The midwife:

- shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices
- facilitates the decision-making process without coercion
- respects the decisions made by the woman, even when these decisions are contrary to her own belief
- attends when requested by the woman in situations where no other health professional is available
- documents decisions and her midwifery actions

Standard Three: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Standard Four: The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.

Standard Five: Midwifery care is planned with the woman.

Standard Six: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.

Criteria

The midwife:

- plans midwifery actions on the basis of current and reliable knowledge and in accordance with Acts, regulations and relevant policies
- ensures assessment is on-going and modifies the midwifery plan accordingly
- ensures potentially life threatening situations take priority
- identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate

  …"

63. The New Zealand College of Midwives' Consensus Statement, "Informed Consent and Decision Making" dated September 2000 states, relevantly:

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"Guidelines

- Informed decision-making involves the exchange and understanding of relevant information. Informed decision-making emphasises the autonomy of the individual. It respects the rights of individuals to make decisions about actions … Making an informed decision is part of a process, which results in either informed consent or refusal.
- Information should be provided in a way that the woman and her family can understand. It must be accurate, objective, relevant and culturally appropriate.
- The information should include:

  The proposed treatment/intervention

  The benefits of the treatment intervention

  …

  What would happen if no treatment/intervention were used

  …
- Documentation should include a brief outline of the information given and when this occurred. All decisions should be clearly documented. Written consent must be obtained where either party requests it.

  …"

Opinion: Ms A — Breach

Introduction

64. Working in partnership with the woman is key to good midwifery practice. In order to work in partnership with the woman, the midwife must ensure that all communication is effective, and that she is responsive to the woman's concerns or anxieties. This case highlights the importance of midwives having an understanding of how different women may react to pain and labour, adjusting their response to the particular woman, and working with her to ensure that she receives the necessary information so that she can be fully informed.

65. This case primarily concerns the care provided by Ms A when Mrs D went into labour at 39 weeks' gestation. Apart from the failure to follow up on the ultrasound scan, which I will refer to below, I am satisfied that the care provided to Mrs D by Ms A from Month1 until 16 Month8 was appropriate.

Missed ultrasound

66. Mrs D said that usually she arranged her own ultrasound appointments. A report would then be sent to Ms A, who would discuss the findings with Mrs D and advise accordingly.

HDC

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67. In a report dated 23 Month4, the radiologist recommended a follow-up scan to check on Mrs D's low-lying placenta. In a further report dated 9 Month5 (at 24 weeks' gestation) the radiologist again noted the need to "reassess the placenta" at 32 weeks. Ms A discussed the report with Mrs D at the 2 Month6 midwifery appointment.

68. Ms A said that at the appointment on 8 Month7 (at 32+5 weeks' gestation) there was a further discussion around the need to do a follow-up scan "but [Mrs D] said she had done the scan and it was all normal". In contrast, Mrs D told HDC that Ms A said: "No, [the baby is] fine, you don't need the [fifth] scan." Mrs A told HDC that she was referring to the fact that the assessments were reassuring in relation to growth rate and normal fetal heart rate. Mrs A recorded in the clinical notes for that day: "[N]eed to follow-up at [the x-ray clinic]." Ms A then forgot to follow up whether Mrs D had in fact had a further scan at 32 weeks.

69. I am faced with conflicting accounts about exactly what arrangements were in place for Mrs D's 32-week ultrasound scan. However:

- if Ms A believed that Mrs D had arranged to have a scan performed herself, she should have obtained the result of that scan and confirmed that there were no further concerns;
- if Ms A ascertained that no scan had been conducted, she should have advised Mrs D to arrange one; or
- if Ms A did not know whether Mrs D had arranged a scan, again, Ms A should have enquired whether a scan had in fact been performed and followed up accordingly.

70. In any event, my view is that Ms A's failure to clarify the situation and follow up on the radiologist's advice to perform a further scan at 32 weeks and review the results was sub-optimal.

Assessments

71. On the day of these events Ms A received two telephone calls from Mrs D and her husband before the home visit at around 4.30pm. My midwifery expert, Kerry Adams, advised that midwives often triage women over the telephone and, although this is accepted practice, it requires the midwife to ask appropriate questions to form a continuing plan of care for either further contact with the woman, or a visit for assessment. Ms Adams advised that Ms A's response to the telephone call at 4.22am was appropriate. I accept this advice.

72. In relation to the 7.30am telephone call where Mr D reported that Mrs D had "lower abdominal pain in the pubic area" which she "could not bear", Ms Adams advised that it appears that Mrs D and the midwife made an interim plan. However, Ms Adams considers that the perception of what that plan was, differed. Ms A said that Mrs D agreed with an interim plan to continue with comfort measures and agreed to remain at home.

73. Mrs D had told Ms A that she had "unbearable period pains". In my view, such a comment indicated that Mrs D as a first-time mother needed support, and was relying

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on Ms A's advice. I am concerned that there was confusion as to when a further assessment would occur. In addition, I note that I am unable to determine whether Ms A carried out an adequate assessment during this telephone call, as she did not document what was discussed. This is concerning, and I refer to this issue in more detail below.

Home visit assessment

74. At 3.30pm Mr D requested that Ms A make an urgent home visit to assess Mrs D. Ms A arrived at approximately 4.30pm. The accounts of what occurred at the visit differ. Mrs D said that Ms A came into her bedroom and that she told Ms A that she was in a lot of pain and that she did not want Ms A to touch her. Mrs D said that Ms A told her that she needed to touch her and Ms A placed one finger on Mrs D's abdomen and checked under the bed covers. Mrs D said that there was not a lot of talking between them, and Ms A did not ask if Mrs D wanted her to check her baby. Mr D said that Ms A told him that she had seen green discharge when she looked under the bed covers. He said that Ms A spent "two minutes, max" in the bedroom and then walked straight out of the house to her car.

75. Ms A said that Mrs D was asleep and did not respond to questions. However, she also said that Mrs D spoke to her. Ms A said she palpated Mrs D's abdomen briefly using the correct methods before Mrs D withdrew her consent to further examination. Ms A said she would have noticed the presence of any green discharge, and does not agree with Mr D's account that she told him that she saw "green stuff". She said she remained in Mrs D's bedroom for 10–15 minutes, then spent another 15 minutes in the lounge, and then waited in her car for a further 10–15 minutes.

76. In a later response to HDC, Ms A said that she called Mrs D's name a few times, asked her, "Don't you want me to check your baby?", and made it clear that further assessment was needed. There is no record in the clinical notes of those comments.

77. I accept that Mrs D consented to Ms A performing some assessment but then withdrew her consent for further examination. I therefore accept that Ms A could not undertake further assessment at that time.

78. After considering all of the statements made, and the clinical records, I find it is more likely than not that Ms A did not explain to Mrs D the importance of being examined further, and the risks of failing to be examined.

79. While Mrs D had the right to refuse consent, she had the right to information that a reasonable consumer in her circumstances needed to make an informed choice to refuse consent. In my view, Ms A should have explained to Mrs D the reasons for doing a further examination, what the examination would involve, and the consequences of not doing an examination. I consider that Ms A was required to discuss with Mrs D the importance of ensuring that Mrs D and her baby were fully assessed as soon as possible, and document that discussion. I note my expert's observation that in the absence of assessments of the maternal blood pressure, pulse and temperature, and fetal heart rate, as well as a vaginal assessment, Ms A was not in a position to diagnose or be suspicious of an infection.

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80. When, during the 9.37pm telephone call, Mrs D asked to go to the hospital, Ms A discouraged her from doing so as she felt that Mrs D was not in established labour. Mrs D told HDC that the "plan" was to continue with comfort measures and go to hospital at the latest possible time, or at a time to be decided by Ms A. Ms A said that Mrs D agreed with the plan; however, Mrs D told HDC that she was in a lot of pain at the time, which she told Ms A, but she felt she could not go against Ms A's advice.

81. The 9.37pm telephone call was the fourth contact since 4.22am. A full assessment of maternal and fetal well-being had not been performed that day, and Mrs D had not had a full physical assessment (either of herself or her baby) since her appointment at 38+2 weeks' gestation (6 days earlier). Furthermore, Mrs D had asked to go to hospital, and this was the third time that she had told Mrs A that she was experiencing severe pain.

82. Ms Adams advised: "[C]onsidering [Mrs D] and her husband had contacted [Mrs A] more than once during the day, the midwife would be recommended to visit the woman (either in her home or at hospital) and do a full assessment." Ms Adams stated that that would have been at the second decision point in labour,[20] and at that stage of Mrs D's labour, Ms A should have asked for more detail around what was happening, such as fetal movements, and checked whether the membranes had ruptured and, if so, asked about the colour, volume, and odour of the liquor. Ms Adams advised that Ms A should have offered Mrs D an assessment, either in her home or the hospital, at this time, and to fail to do so was a moderate deviation from expected standards. I agree with this advice.

83. The decision not to go to hospital at that stage was based largely on information obtained via telephone, and not a physical assessment. In my view, the "plan" should have been reassessed at the time of the 9.37pm telephone call, and a follow-up visit offered or hospital admission arranged promptly. In addition, the questions Ms A asked were inadequate to gain a full clinical picture. Given that there had been three earlier contacts and a failed attempt at an assessment at 4.30pm, I consider that Ms A should have attended and completed a full assessment at home or advised Mrs D to go to hospital. In my view, Ms A's failure to arrange to examine Mrs D herself or advise her to go to hospital was poor care, and demonstrates a regrettable lack of support for a first-time mother.

Record-keeping

84. The *Midwives Handbook for Practice* requires midwives to collate and document comprehensive assessments of the woman and/or baby's health and well-being and maintain purposeful, ongoing, updated records and make them available to the woman and other relevant persons. Competency Two of the MCNZ Competencies, 2.16 states: "[The midwife] provides accurate and timely written progress notes and relevant documented evidence of all decision made and midwifery care offered and provided."

[20] When the woman wants intermittent support from the midwife — p 35 *Midwives Handbook for Practice*. NZCOM says that the decision points for midwifery care "identify those times when there ought to be an assessment during pregnancy and childbirth".

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85. Ms A did not document what was discussed during the telephone calls at 7.30am and 9.37pm. Ms A said that the telephone call at 9.37pm was not recorded in Mrs D's notes because she did not have Mrs D's notes with her at the time. Ms Adams stated:

> "[I]t is a legal requirement to document notes in a contemporaneous way. If [Ms A] did not have [Mrs D's] notes in her possession it would be advisable to document all phone calls/texts/visits as they occur and then add to the woman's 'hand-held' notes when appropriate."

Conclusions

86. In my view, Ms A failed to provide services to Mrs D with reasonable care and skill by:

- failing to follow up the advice from the radiologist and ascertain whether a 32-week ultrasound scan had been performed; and
- failing to arrange a full assessment of Mrs D either in her home or at hospital at 9.37pm on 22 Month8.

87. For the above reasons, I find that Ms A breached Right 4(1) of the Code.

88. At the home visit at 4.30pm on 22 Month8, when Ms A interpreted Mrs D's comments and actions as declining further assessment, Ms A did not explain the reasons for performing a further examination, what the examination would involve, and the consequences of not doing an examination. This was information that a reasonable consumer in Mrs D's circumstances required before making the choice to refuse consent. Accordingly, I find that Ms A also breached Right 6(2) of the Code.

89. By failing to document significant events, discussions and decisions, I consider that Ms A did not meet professional standards and, accordingly, she breached Right 4(2) of the Code.

Recommendations

90. I recommend that Ms A:

a) Apologise to Mrs D for her breaches of the Code. The written apology is to be forwarded to this Office within three weeks of the date of this report, for forwarding to Mrs D.

b) Arrange further training on record-keeping, documentation, informed consent and care for women in labour, and provide HDC with confirmation of her attendance at the appropriate workshops.

91. Ms A should provide a report to this Office within three months of the date of this report, confirming her compliance with recommendation (b) above.

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92. I recommend that the Midwifery Council of New Zealand conduct a review of Ms A's competence.

Follow-up actions

93. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand and the district health board, and they will be advised of Ms A's name.

94. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent midwifery advice to the Commissioner

The following expert advice was obtained from Ms Kerry Adams:

"I have been asked to provide an opinion to the Commissioner on case number C14HDC01440. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Kerry Adams and I am a Registered Midwife. I have a Bachelor of Midwifery Degree which I gained through Otago Polytechnic in 1999. I also have a Postgraduate Certificate in Midwifery, also gained through Otago Polytechnic, in 2007. I have been a member of the Midwifery Council of NZ's Professional Conduct Committee since 2012 and I am the current NZCOM endorsed Midwifery Advisor for the National Screening Unit's Newborn Metabolic Screening Governance and Technical groups. I have been the midwifery panel member alongside the consumer member of the Midwifery Resolutions Committee since 2011. I am also currently mentoring a newly graduated midwife in the Midwifery First Year of Practice Mentoring Programme, I have been a mentor through this programme on and off since 2008. I am currently employed by the School of Midwifery at Otago Polytechnic as a full time lecturer and I continue to run a small LMC midwifery practice in Dunedin with a couple of my School of Midwifery colleagues.

Please find attached my opinion in response to the request and a factual summary of events

Issue One

'Were appropriate antenatal assessments undertaken to assess baby's growth?'

It appears from all documentation provided that [Ms A] undertook all appropriate assessments during the antenatal period. At each visit it is documented that [Ms A] carried out the following assessments:

- *blood pressure (BP)*
- *urine dipstick to assess for presence of protein or glucose to name a few*
- *palpation of [Mrs D's] abdomen and tape measure assessment of fundal height*
- *listened to fetal heart rate with a doppler*
- *plotted abdominal growth on a customised growth chart*
- *assessment of [Mrs D] for signs of oedema*
- *conversation around fetal movements*
- *documentation of all assessments and discussions and plans for further care*

Although there is some evidence that a customised growth chart (see Cochrane Review and NZCOM Consensus Statement) combined with fundal height measurements (or serial growth scans) may increase the chance of identifying babies who are either small for dates or growth restricted, this information is to

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be used with caution as more research needs to be undertaken to provide evidence for this practice. With this in mind [Ms A] carried out all assessments in line with current best practice to monitor the growth of [Mrs D's] baby. There does not appear to be any departure from the accepted level of care.

Issue Two
'Were there any signs that the baby's growth was restricted, or that [Mrs D] had developed an infection?'
As [Ms A] had palpated [Mrs D's] abdomen, measured fundal height and was entering information onto a customised growth chart, she had been carrying out the appropriate assessments to ensure she was monitoring [Mrs D's] baby's growth. It appears from documentation that there did not appear to be an issue around the growth.

With reference to any signs of infection, all maternal assessments carried out and documented in [Mrs D's] clinical notes up until 22 [Month8] led me to believe there were no obvious signs of infection.

As there were no assessments in relation to maternal BP, pulse, temperature or respiratory rate taken, or fetal heart rate, maternal observations relating to palpation or vaginal assessment due to [Mrs D's] declining any examination it would be difficult for [Ms A] to have diagnosed or be suspicious of any signs of infection ([Ms A's] statement and [Mrs D's] clinical notes). [Mrs D] has given a different version of the events on the 22 [Month8] and this is examined in the next section of my response.

Issue Three
'Do you consider that [Ms A] acted appropriately in response to the symptoms reported by [Mrs D] on 22 [Month8]?'

[22 Month8]

- phone call at 0422hrs — [Mrs D's] husband called reporting [Mrs D] had a 'water white discharge when she got up to the toilet'. [Ms A] had a discussion with [Mr D] and it was established that this appeared to be normal vaginal discharge. [Ms A] was advised there were 'no labour pains and baby was moving'. ([Ms A's] statement, [date])

This would appear to be an appropriate response from [Ms A] as she had established that [Mrs D] was not in labour and there were no other concerns reported by [Mrs D] therefore [Mrs D] did not need immediate care or treatment.

- phone call at 0730hrs — [Mr D] called [Ms A] to state that [Mrs D] was having some 'lower abdomen pain in the pubic area' and according to [Mr D] 'she could not bear it'. [Ms A] asked to speak with [Mrs D]. [Ms A] established in the conversation with [Mrs D] that [Mrs D] was experiencing painful lower abdominal pains described as 'unbearable period pains'; these were short in duration (30 seconds) and approximately every 10 minutes. [Ms

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A] discussed with [Mrs D] that labour appeared to be starting and gave her some advice around comfort measures and advice around what to expect when labour became stronger. She gave [Mrs D] some advice around comfort issues (although what advice she gave her is not documented). [Ms A] advised [Mrs D] she would see her later in the day as labour establishes. According to [Ms A] she reported that [Mrs D] appeared to calm with the advice and was happy with this plan. ([Ms A's] statement, [date])

There is a discrepancy in [Ms A] and [Mrs D's] statements at this point as [Mrs D] says that [Ms A] was to visit her at home at 1500hrs that day and when she didn't [Mrs D] called [Ms A] to attend her. ([Mrs D's] complaint letter of [date]). I cannot comment which discussion was correct, however a plan had been made for further contact for later, on the day of the 22 [Month8].

According to the first decision point in labour in the Midwives Handbook for Practice (NZCOM, 2008), this is an opportunity for the midwife to determine the woman's need for 'assessment and ongoing midwifery care' p34.

[Ms A] did an 'over-the-phone' assessment and it appears both the woman and the midwife came to a decision about what the plan would be for the interim prior to needing a visit for assessment or admission to the maternity unit. However the perception of what this decision was seems to differ. [Mrs D's] documented clinical notes do not reflect what was discussed in this phone call.

- phone call at around 1500/1530hrs — [Mr D] called requesting [Ms A] visit [Mrs D]. [Ms A] recalls in her statement ([date]) that she turned back from the direction she was going in to visit and attend to [Mrs D]. In [Mrs D's] complaint letter ([date]) she was of the understanding that [Ms A] was to visit her at home at 1500hrs. *This is an obvious discrepancy. There could well have been a miscommunication about when the visit was; however I cannot make comment or any assumption as I do not know which account was correct.*

- 1645 visit at home — [Ms A] attended [Mrs D's] home as requested. According to [Ms A's] statement ([date]) she reports that when she arrived at [Mrs D's] home, [Mrs D] was in bed and appeared asleep. [Ms A] states that [Mrs D]:
    - Did not respond when [Ms A] called her name and advised she was there to check her baby and progress.
    - Did not respond to any of her questions (statement of [date] and [Mrs D's] clinical notes)

[Ms A] discussed with [Mr D] that [Mrs D] did not appear to be in strong labour. [Mrs D] responded to this to say she was not asleep. [Mrs D] was reported to have her eyes closed and was quietly in the bed. She stated she had a pain and [Ms A] put her hand on [Mrs D's] abdomen to palpate and [Mrs D] asked/ordered her not to touch her anymore (statement of [date] and [Mrs D's] clinical notes).

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[Ms A] reported in her statement ([date]) and in [Mrs D's] notes that 'there was no evident contraction and the pain appeared to be in the lower abdomen typically like cervical cramps' and perhaps [Mrs D] had some mild contractions. [Ms A] asked [Mrs D] if she could examine her but [Mrs D] told her to 'leave me alone'. She asked [Mrs D] if she could check under the covers to see if there was any discharge and [Mrs D] consented. Mrs A noted that [Mrs D] was not wearing a pad and she noted that she observed a clear mucous show. [Ms A] asked [Mrs D] if the baby was moving and reports that [Mrs D] 'replied affirmatively' (statement of [date] and [Mrs D's] clinical notes).

[Ms A] reported that [Mrs D] continued to close her eyes and lie still and would not respond when she spoke to her. [Ms A] states that [Mrs D] did not mention she was in pain, nor did she express any concerns at any time. [Ms A] reports she spoke to [Mr D] about what to do. [Mr D] also stated that [Mrs D] would not let him touch her either. [Ms A] explained she could not examine [Mrs D] without permission and had done as much as she could do in the circumstances. [Ms A] reports she waited for 15 minutes in case [Mrs D] changed her mind about being examined. [Ms A] advised the couple that women usually go to hospital when in established labour and to call her if labour became stronger or if there were any concerns and then [Ms A] left.

There is again discrepancy between [Mrs D's] complaint letter, and [Ms A's] statement and what is written in [Mrs D's] midwifery clinical notes. [Mrs D] reports that she was in so much pain she was unable to respond to questions and that [Ms A] had not checked her baby. Considering [Ms A] had carried out thorough antenatal assessments it would seem odd that [Ms A] would have left [Mrs D's] house not having offered to carry out early labour assessments.

[Ms A] responded according with the second decision point in labour concurring with the Midwives Handbook for Practice (NZCOM, 2008). This decision point provides for a further opportunity for assessment of the woman in labour and when the woman wants intermittent support from the midwife. The decision point is about information sharing and emotional support and physical assessment of the woman. However at this point [Mrs D] appears to have declined care, according to her clinical notes and [Ms A's] ([date]) statement. [Mrs D] gives another version of the event in which she says that [Ms A] did not carry out any assessments and only stayed for a few minutes.

If indeed [Mrs D] did decline any maternal and fetal assessment from her midwife then [Ms A] in accordance with The HDC Code of Health and Disability Services Consumers' Rights Regulation (HDC, 1996), has to respect her right to refuse care. Under the Standards for Midwifery Practice (NZCOM, 2008) Standard Two also supports the right of each woman to free and informed choice and with this the right to decline treatments or procedures.

[Ms A] reports she stayed in her car outside the house as she was concerned about the fact that she had been unable to provide an assessment of [Mrs D] and her baby while stating that she was aware that women have the legal right to decline

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care. She also commented that it was [Mr D] who had asked her to attend [Mrs D] and not [Mrs D].

- 2137 phone call from [Mr D] — reporting [Mrs D's] pains had increased in intensity. [Ms A] asked to speak to [Mrs D]. She reports (as does [Mrs D]) that they spoke for around 20/25 minutes on the phone. [Ms A] reports that contractions appeared to be 10 to 15 minutes apart and were 'short'. There is no entry of this phone call in [Mrs D's] clinical notes. [Ms A] advised [Mrs D] of:
  - all the comfort measures discussed earlier
  - explained it was not time to go to hospital but if she did then she could be checked for progress. If she was still not in established [labour] then she could have pethidine and stay in the antenatal ward but her husband would be unable to stay. [Mrs D] states in her complaint letter and [Ms A's] statement concurs that [Mrs D] did not care about these things.

[Ms A] indicated in her statement that she calmed [Mrs D] and encouraged her that she could cope with staying at home. [Ms A] believes that she had not coerced [Mrs D] to stay at home and she had left the option to go to hospital open.

[Ms A's] clinical notes for [Mrs D], does not reflect any documentation around this phone call. I am unsure at this time what assessments were carried out over the phone such as asking [Mrs D]

- *was* her baby moving?
- was she leaking any fluid (membranes ruptured) if so what was colour, smell or volume?
- was she feeling *well?*

Although [Ms A] may have asked these questions of [Mrs D], this information was not documented in [Mrs D's] clinical notes. The only assessment documented in [Ms A's] statement was her questioning around the contractions [Mrs D] was experiencing. Whenever there is an interaction with a woman the midwife is caring for it is both a legal requirement and best practice to document these phone calls.

In light of the current clinical scenario and that there had been no thorough maternal or fetal assessments carried out on [Mrs D] since the last visit at 38+2 weeks gestation, it may have been worth offering to see [Mrs D] at either her home or in hospital to assess progress. Although [Mrs D] appears to have declined examination earlier in the day, another discussion could have been initiated around a full assessment considering [Mrs D] had been in what [Ms A] had diagnosed, early labour, for a period of time. Although this may well not have changed the outcome it may have reassured [Mrs D] and her husband and provided a baseline for ongoing care. As there is no proof whether there was, or was not, further assessments over the phone then it cannot be assumed that there was a departure from the standard of care or accepted practice for women in early labour.

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- 2334 phone call from [Mr D] — [Mrs D] had increased pain and was feeling pressure. [Ms A] advised them to head to the hospital.

This would be in line with appropriate care and best practice for the clinical scenario.

Issue Four

'Was it appropriate for [Ms A] to leave after [Mrs D] refused to be examined?'

At the point when a woman has refused care or assessment it makes it difficult for a midwife to continue to provide care effectively. The balance between the woman declining care and the midwife ensuring the woman is aware of the clinical situation and coerces consent from her is a fine line.

When women decline care, the midwifery profession and the Ministry of Health in the Referral Guidelines (2012) advises that the midwife (or the practitioner) documents all discussions and plans and ensures that the midwife/practitioner revisit the woman's choices to ensure discussion continues and opportunities for the woman to change her mind are revisited. Although the Referral Guidelines (2012) relate to referral to other services the intent of the document is the same in referring to situations when women decline care, but to other practitioners.

This left [Ms A] in a difficult situation. It appears she discussed a plan with [Mrs D] and her husband around contacting her if there were any changes to her labour or if they were concerned and she had established that [Mrs D] was in early labour and [Mrs D] was feeling movements of her baby. [Ms A] documented in her statement that she was feeling unease at leaving [Mrs D's] house without being able to carry out any further examinations.

[Ms A] documented the assessments she had been able to carry out, discussions she had attempted with [Mrs D] and a discussion she had with [Mrs D's] husband, [Mr D]. She documented a plan for further contact when labour became stronger and contractions became closer together. In my view this was within a standard of care or accepted practice and there was no departure from care. The clinical scenario of when a woman declines care or assessments remains an area of anxiety for midwives and it appears that [Ms A] felt deeply uncomfortable but unable to act when [Mrs D] did not wish to be examined.

Further advice 7 April 2015

In addition to this, under issue 3 and the phone call of 21:37 (pages 7–8) you state: '*As there is no proof whether there was, or was not, further assessments over the phone then it cannot be assumed that there was a departure from the standard of care or accepted practice for women in early labour.'*

With regards to this, I would be grateful if you could advise on the following:

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If it is established that no assessments were carried out in the phone call of 21:37, do you believe this would represent a departure from expected care? If you do, please advise the level of departure and discuss how this departure would be viewed by your peers.

It is a fact that there was no documentation from this phone call at 2137 on the 22 [Month8]. It would be reasonable to assume that there had been a phone assessment of [Mrs D] by [Ms A] as she had remained on the phone with [Mrs D] for 25 minutes ([Ms A's] statement of [date]). This appears to be quite some time and would have allowed [Ms A] to have established some assessment of [Mrs D's] current clinical situation.

I advise for this point that there is no departure from a reasonable standard of care.

If it is established that during the phone call of 21:37, assessments were carried out, but not documented, do you believe this is a departure from the expected standards? If so please advise the level of departure and discuss how this departure would be viewed by your peers.

As there had been no documentation of the phone call at 2137 and assessments were carried out then there would be a departure from expected standards. Under Competency Two of the MCNZ (2007) Competencies, 2.16 it states '[the midwife] *provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided'.*

This would therefore in my opinion be a mild departure from expected standards in relation to documentation.

<u>Further advice 10 July 2015</u>

<u>Point One</u>

[Ms C] has made comments on a number of issues of which I was not asked to comment on in my previous responses.

'Failure to exclude late pregnancy placenta previa as twice directed by radiology reporting'

[Ms C] is quite correct that USS assessment should have either been followed up and/or arranged by the LMC [Ms A] to assess and confirm if [Mrs D] had placenta previa and required referral to obstetric services. This follow-up USS is usually performed at 32 weeks gestation (or around this time in the third trimester). 'When the placental edge reaches or overlaps the internal os on TVS between 18 and 24 weeks' gestation (incidence 2–4%), a follow-up examination for placental location in the third trimester is recommended' (Oppenheimer, 2007).

[Ms A] also states in her further statement (n.d) that on the visit [when Mrs D] was 32+5/40, [Mrs D] informed [Ms A] that the 'scan had been done and it was all normal'. [Ms A] commented that she was surprised as she did not recall the scan result, had no record and was unable to check on the [public hospital] system. [Ms

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A], in this same statement, recorded that she needed to 'follow up'. [Ms A] acknowledges she did not follow up this result. I agree with [Ms A] that if at 32 weeks there remained a low lying placenta this would necessitate a referral to the obstetric team. However as follow up had not occurred to discount this diagnosis, then it does not matter what [Ms A] discussed in her statement around what plan of care is made around which hospital [Mrs D] would birth in and at what gestation. The issue is that this plan of care following a third trimester USS had not occurred as follow up had not been completed and the third trimester USS had not happened.

'Failure to respond adequately to [Mrs D's] concerns on [22 Month8]'

As discussed before we cannot assume the content of discussions had by telephone between [Ms A] and [Mrs D], as most of these discussions were not documented. However [Ms A] has provided some content to what would have been discussed as per the phone call at approximately 21.37 on the [22 Month8].

I cannot respond to any of the potential ways in which [Mrs D] or [Mr D] were feeling either physically or emotionally in regards to whether [Mrs D] was in labour or not and what her stage of labour was, as this is speculation and there is no documentation which would confirm the conversation had around these issues apart from the frequency and length of those contractions. However in [Ms A's] first statement she had discussed that after a conversation with [Mrs D] and her husband that they were happy with the plan of care discussed during that phone call at 21.37 and the plan to continue to stay at home. However [Mrs D] has given an alternative view of this and stated that she wished to go to hospital and 'didn't care' about whether examinations would take place.

[Ms A] quite rightly states that midwives often triage women over the phone. This is accepted practice and requires the midwife to ask appropriate questions to form a continuing plan of care for either further contact or assessment, as per the first Decision Point in Labour in the Midwives Handbook for Practice (NZCOM, 2008. p34). After nearly 16 years of practice and teaching midwifery assessment and care to undergraduate midwifery students I am very familiar with this practice. However my comment remains the same in regards to documentation of those calls as per my statement of 30/03/15:

'Whenever there is an interaction with a woman the midwife is caring for it is both a legal requirement and best practice to document these phone calls'.

Also from the statement of 07/04/15:

'*Under Competency Two of the MCNZ (2007) Competencies, 2.16 it states "[the midwife] provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided".'*

In response to [Ms A's] comments in her latest statement around documentation, I would like to remind [Ms A] that it is a legal requirement to document notes in a contemporaneous way. If she did not have the woman's notes in her possession it

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would be advisable to document all phone calls/texts/visits as they occur and then add to the woman's 'hand-held' notes when appropriate. It is good that [Ms A] understands that she will do this in future, however not just when she has access to clinical records.

As per my first opinion document (30/03/15), when [Ms A] visited [Mrs D] at home, it was documented that [Mrs D] was clear she did not want to be touched. My opinion remains the same on this matter and I disagree with [Ms C's] comments and assumptions of how [Mrs D] may or may not have felt or behaved at this visit as [Ms C] was not present. We can only go on the original statements of the midwife and the woman. I again reiterate as per my first opinion that care cannot be carried out when a woman declines. As per my first opinion of 30/03/15 my statement as follows remains the same:

'If indeed [Mrs D] did decline any maternal and fetal assessment from her midwife then [Ms A] in accordance with The HDC Code of Health and Disability Services Consumers' Rights Regulation (HDC, 1996), has to respect her right to refuse care. Under the Standards for Midwifery Practice (NZCOM, 2008) Standard Two also supports the right of each woman to free and informed choice and with this the right to decline treatments or procedures.'

If [Ms A] had carried out assessments against [Mrs D's] wishes then she would be breaching [Mrs D's] rights according to the above code and standards.

I cannot comment and make any assumptions on how long [Mrs D] was in labour. However in general it is not unheard of for primigravida women to have a latent stage of labour, progressing to a quick birth following the onset of established labour. With this in mind I disagree with [Ms C's] statement that 'such a quick labour as guessed by the midwife would be unlikely for anyone experiencing their first full time pregnancy and labour' (n.d). In my 16 years of practice I have certainly had experience of primigravida women who once in established labour, birth in under four hours. Although not common, is certainly not rare.

'Chorioamnioitis and intrauterine growth restriction'

In [Ms C's] comments she notes the difference in centiles from the 24 week USS to the baby's birth weight. She notes that a follow up USS at 32 weeks as 'repeatedly advised could have led to closer scrutiny to be arranged'. While you could say that there could well have been an issue around growth of the baby from the 24 week USS, however there most certainly would not have been reference made to there being the presence of any infection. This would not have been identified by USS examination.

We know that USS is not reliable in detecting IUGR or general estimation of fetal weight, especially when used in isolation of other USS serial scanning and assessments. Customised Growth Charts combined with fundal height measurement and monitoring of fetal movements, although again not 100% reliable have been found to be a better predictor of fetal wellbeing and estimated fetal weight (although further research needs to be carried out) (Carberry et al, 2014). Customised growth charts take into consideration a number of other factors such as the height and weight of both parents (BMI) and ethnicity to name a few,

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which informs a better predication of estimated fetal weight. [Ms A] had carried out a customised growth chart for [Mrs D] and had found no evidence for concern at the time. [Ms A] in her latest statement has provided two good sources of literature to support these points.

…

In [Ms A's] latest statement regarding the telephone conversation she had with [Mrs D] she stated the following:

'I listened to [Mrs D] as she experienced her pains they were short and irregular, 10–15 minutes apart ... I encouraged [Mrs D] and reminded her about breathing through contractions rather than fighting them, keeping calm, using distraction, water, heat packs, resting between contraction, keeping herself hydrated and to eat something and to use Panadol if she wished ... I explained about triaging, the hospital expectations and environment.' (n.d)

At this point, considering [Mrs D] and her husband had contacted Mrs A more than once during the day, the midwife would be recommended to visit the woman (either in her home or at hospital) and do a full assessment (NZCOM, 2008). As [Ms A] had visited [Mrs D] earlier in the day and had been unable to physically assess [Mrs D] and her baby's wellbeing she would have needed to have asked the following questions in her telephone conversation as per the Midwives Handbook for Practice (NZCOM, 2008. p35) in relation to the second decision point in labour — when the woman wants intermittent support from the midwife.

- Assess the woman's well-being, including her emotional and behavioural responses — **[Ms A] gave [Mrs D] advice around coping methods.**
- Check how the woman is feeling about the labour and whether she wants on-going support from the midwife — **[Mrs D] had at this point asked to go to hospital (in her first statement) and had been discouraged by [Ms A]. However [Ms A] had discouraged her (as per [Ms A's] first statement) as she felt [Mrs D] was not in established labour and [Mrs D] had agreed with this plan (not aligned with [Mrs D's] statements).**
- Assess contractions, length/strength/frequency — **carried out by [Ms A].**
- Assess baby's wellbeing — **could have asked about fetal movements but [Ms A] did not ask.**
- Check if membranes had ruptured, if so colour/volume/odour — **[Ms A] did not ask.**

In my opinion [Ms A] should have asked for more detail around what was happening at this point in [Mrs D's] labour. I had indicated in my previous statement of the 30/03/15 the following:

'In light of the current clinical scenario and that there had been no thorough maternal or fetal assessments carried out on [Mrs D] since the last visit at 38+2 weeks gestation, it may have been worth offering to see [Mrs D] at either her home or in hospital to assess progress. Although [Mrs D] appears to have declined examination earlier in the day, another discussion could have been initiated around a full assessment considering [Mrs D] had been in what [Ms A] had diagnosed, early labour, for a period of time. Although this may well not have

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changed the outcome it may have reassured [Mrs D] and her husband and provided a baseline for ongoing care…"

In light of the new information concerning what was covered in the phone call to [Ms A] from [Mrs D] and [Mr D] on the 22 [Month8] at approximately 21:37, and:

- [Mrs D] had requested to go to hospital at that time and
- A full assessment of maternal and fetal wellbeing had not been ascertained and
- [Mrs D] had not had a full physical assessment of either her or her baby since her last appointment at 38+2 weeks gestation;

it remains my opinion that [Mrs D] should have been offered an assessment either in her home or the hospital at this point in time. This may not have changed the tragic outcome for the baby of [Mrs D] and her husband however as previously stated in my opinion of 30/03/15, it may have provided a better baseline for on-going care.

In relation to Competency Two of the Competencies for Entry to the Register of Midwives (MCNZ, 2007), competency 2.5 '*attends, supports and regularly assesses the woman/wahine and her baby/tamaiti and makes appropriate, timely midwifery interventions throughout labour and birth'*. In my opinion this did not happen to a standard of care or accepted practice in relation to midwifery care.

In my opinion in relation to the level of care in [Mrs D's] labour and birth this represents a departure from standard care or accepted practice. I would determine that this is a moderate deviation considering all the information provided.

Further advice 16 July 2015

In relation to [Ms A] not following up on ordering an USS or following up on any USS result, I would like to add the following comments:

Not following up on the result of the 32 week USS [Mrs D] had reported had been 'done and was fine' in my opinion is a mild deviation from an accepted standard of practice. [Ms A] by her own admission agrees that she should have followed up on this result or my opinion should have ordered a follow up appointment for an USS at 32 weeks to discount or diagnose placenta previa. This is a mild deviation as it relates to Standard six in the Midwives Handbook for Practice (NZCOM, 2008) in which it is stated that *'midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.'* (p20)

With the benefit of hindsight [Mrs D] did not have the condition of placenta previa and had she had any episodes of per vaginal bleeding, the main sign of a possible placenta previa, then without making any assumptions of how [Mrs D] or [Ms A] would have behaved, one would hope that [Ms A] would have responded appropriately to this possible emergency."

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